Senate Budget & Fiscal Review
Senator Wesley Chesbro, Chair

Subcommittee No. 3
on
Health, Human Services, Labor, and Veterans Affairs

Senator Wesley Chesbro, Chair
Senator Gilbert Cedillo
Senator Tom McClintock
Senator Bruce McPherson
Senator Deborah Ortiz

Thursday, April 22, 2004
Upon Adjournment of Senate Floor Session
Room 4203

Consultant, Ana Matosantos

Due to the volume of issues testimony will be limited.
Please be direct and brief in your comments so that others may have the opportunity to testify.
Written testimony is also welcome and appreciated.
Thank you for your consideration.

5180 Department of Social Services

The Department of Social Services (DSS) administers various programs designed to enable low-income aged, blind and disabled individuals to live independently. The programs include California Veterans Cash Benefit, In-Home Supportive Services, and Supplemental Security Income/State Supplementary Payment. These programs serve approximately 1.5 million persons each year. The Governor's Budget provides approximately $11 billion in combined federal, state and county funds to support these programs.

Summary of Program funding (dollars in thousands)	2003-04	2004-05	$ Change	% Change
Program Expenditures				
California Veterans Cash Benefit Program	4,049	0	-4,049	-100.0
In-Home Supportive Services (IHSS)	3,215,313	2,763,356	-451,957	-14.1
SSI/SSP	8,030,972	8,202,844	171,872	2.1
Total Program Expenditures	$11,250,334	$10,966,200	-$284,134	-2.53
Source of Funding				
General Fund	4,337,286	4,166,650	-170,636	-3.9
Federal Funds	6,294,920	6,314,701	19,781	0.3
County Funds	618,128	484,849	-133,279	-21.6
Total	$11,250,334	$10,966,200	-284,134	-2.53

I. California Veterans Cash Benefit Program

Background: The California Veterans Cash Benefit Program, established by Assembly Bill 1978 (Chapter 143, Statutes of 2000), provides cash assistance to Filipino veterans of World War II who were receiving state supplementary payment benefits on December of 1999 and who have returned to the Republic of the Philippines. The veterans receive a payment equivalent to California's state supplemental payment ($226 per month). The veterans also receive a federal cash benefit, which currently amounts to $414 per month. The California Veterans Cash Benefit program serves approximately 1,700 veterans on an annual basis.

Governor's Budget: The Governor proposes to eliminate the California Veterans Cash Benefit Program for General Fund savings of $1.2 million in the current year and $5.5 million in 2004-05. Veterans will continue receiving existing federal benefits.

Constituency Comments: Opponents of the Governor's proposal argue that the elimination of the California Veterans Cash Benefit Program would be a disservice to the contributions of Filipino veterans who fought side-by-side with U.S. soldiers in World War II. Opponents also argue that the proposal is fiscally unsound as a loss of benefits could trigger veterans to return to the United States and increase their reliance on government funded services including health care services.

Subcommittee request and questions: The Subcommittee has requested that the Department of Social Services describe the proposal and discuss how the proposal will impact the veterans served by the California Veterans Cash Benefit Program.

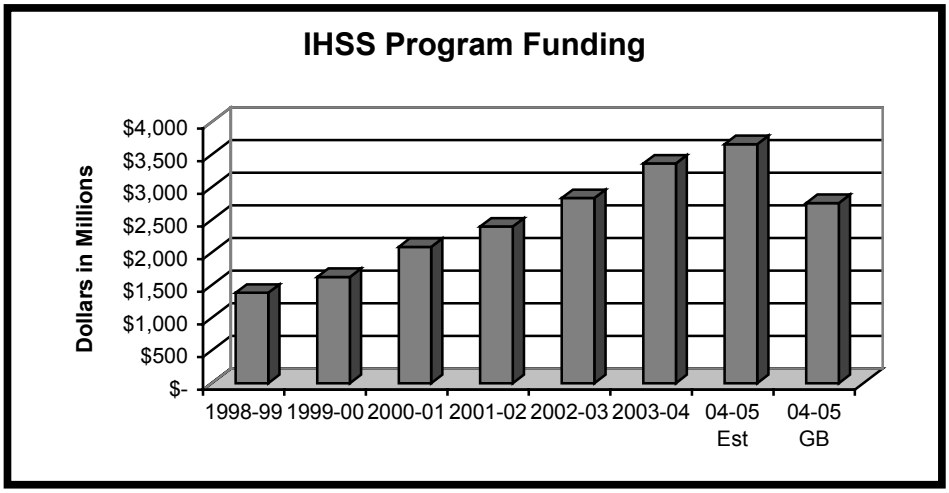
Budget issue: Does the Subcommittee wish to approve the proposed program elimination?

II. In-Home Supportive Services

Background: The In-Home Supportive Services (IHSS) program provides services to 359,000 low-income aged, blind or disabled individuals that allow them to remain safely in their own homes as an alternative to out-of-home care. IHSS is the largest home and community-based program available in California and is a core component of the state's long-term care system. IHSS services include domestic services, nonmedical personal care services, paramedical services, assistance while traveling to medical appointments, teaching and demonstration directed at reducing the need for support, and other assistance. Services are provided through individual providers, county contracts with service providers, or through welfare staff.

Summary of Funding:
IHSS is funded by a combination of federal, state and county funds. Program services eligible for federal financial participation are provided through the Personal Care Services Program (PCSP), while services ineligible for federal reimbursement are provided through the Residual Program. Eighty-one percent of services are provided through PCSP. PCSP services are a Medi-Cal benefit; therefore, the federal government funds approximately 50 percent of program costs. Nineteen percent of IHSS services are provided through the Residual program. The state and counties fund the non-federal share of IHSS costs, including Residual, at a ratio of 65% to 35%.

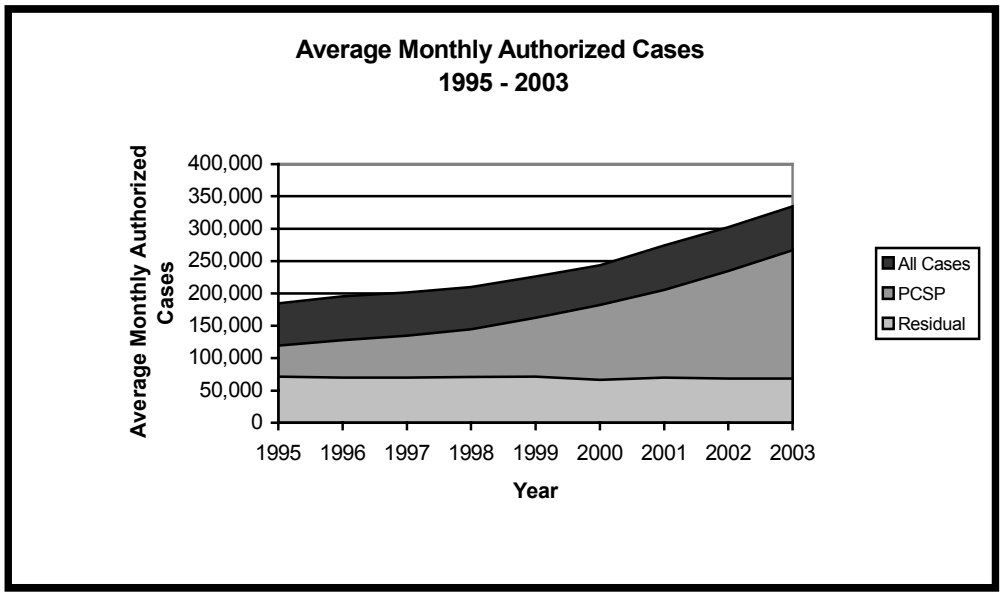
The total cost of the IHSS program has more than doubled from $1.39 billion in fiscal year 1998-99 to $2.8 billion in 2002-03. Absent statutory changes, IHSS program costs are estimated to rise to $3.7 billion ($1.4 billion GF) in 2004-05.



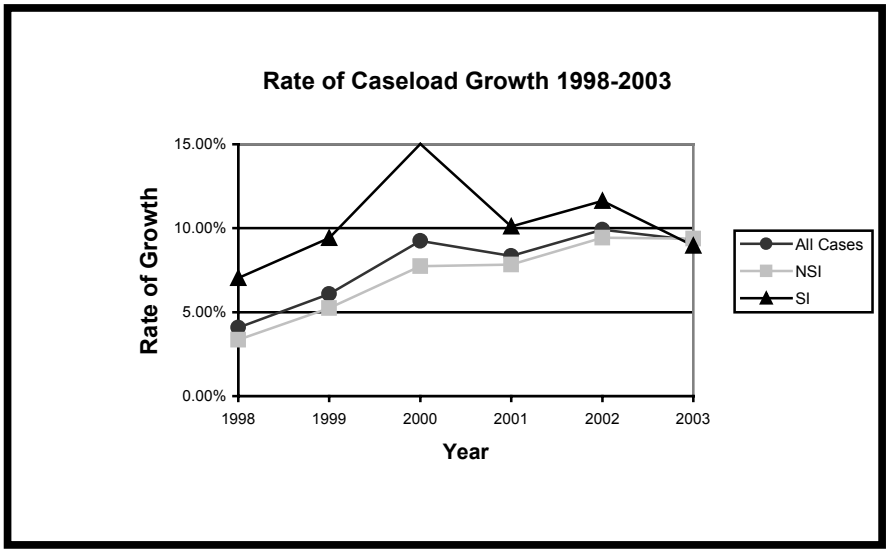
*****The chart illustrates the estimate of IHSS program costs absent statutory changes and the Governor's Budget proposed level of funding for IHSS.***

Summary of Caseload:
IHSS provides services to 359,000 low-income aged, blind or disabled individuals, the vast majority of whom are SSI/SSP and Medi-Cal enrollees. Fifty one percent of IHSS consumers are disabled, 47 percent are aged, and two percent are blind. Persons with developmental disabilities constitute a significant portion of the IHSS caseload (more than 12 percent).

Total IHSS cases increased 64 percent from 1995 to 2003. The PCSP caseload has grown by 96 percent, while the IHSS Residual caseload has declined slightly.

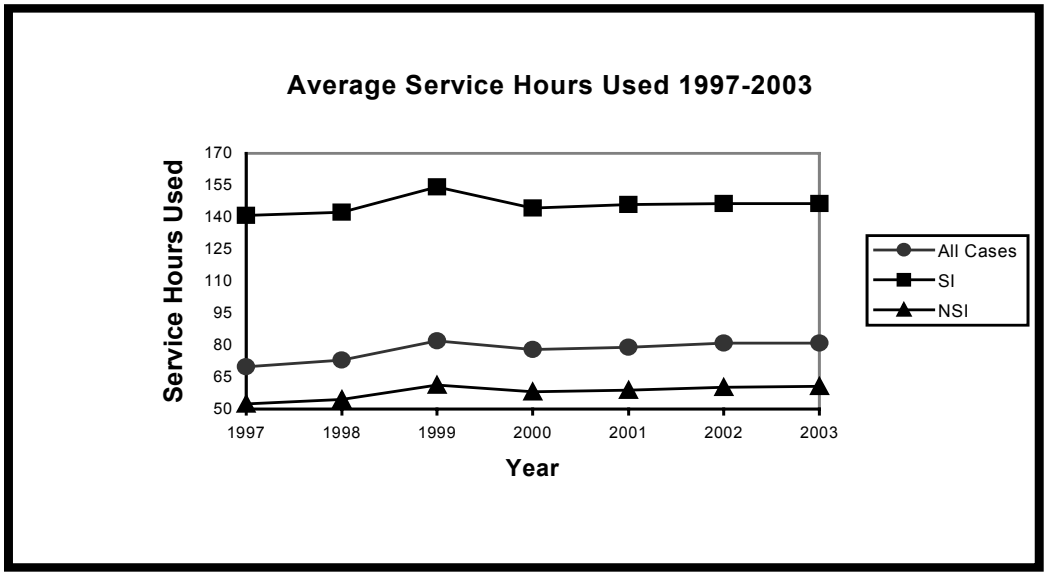


While the IHSS caseload has grown across categories, the proportion of consumers with disabilities has grown at a faster rate. Severely impaired cases have also grown at a faster rate than non-severely impaired cases. (Severely impaired cases are defined as cases that need more than 20 hours of personal care services per week.)



IHSS is serving a growing population of relatively young consumers with disabilities that require more hours of service and remain in the program for a longer period of time. Consumers generally remain in the program for at least 4 years, with aged consumers using services for a shorter period of time, while younger persons with disabilities remain in the program longer.

Summary of Service Hours:
Changes in caseload composition have contributed to a higher utilization of service hours in the IHSS program. The total number of IHSS service hours delivered in a given year has increased by 61 percent since 1997. The average hours utilized in a month per IHSS consumer has risen by 16 percent to 81 hours per case. However, growth in service hour utilization varies by consumer type. Severely impaired (SI) consumers use 4% more hours than they did in 1997, while service hour utilization has increased by 16% among the not-severely impaired (NSI). Additionally, service hour utilization by type of case varies from county to county, but remains below the caps across the state (283 for SI cases, 195 for NSI cases).



Since the mid-1990s the IHSS caseload, hours of service, and program costs have grown. However, to the extent that the program succeeds in keeping low-income aged, blind or disabled individuals in their own homes as an alternative to out-of-home care, it is cost-effective to the state as costs per individual are less than one-fourth the costs of nursing home placement.

Analysis conducted by the California Center for Long-Term Care Integration suggests that IHSS and other home and community-based services may have helped reduce nursing home utilization in California. Since the 1990s, the number of Medi-Cal eligibles over age 65 has increased almost 25%, yet the average nursing home utilization has decreased from almost 44 days per Medi-Cal eligible aged 65+ in 1991 to just over 36 days per eligible in 2001. The Center's findings are consistent with the state's overall decrease in nursing home occupancy rates (from 85 percent in 1992 to 81 percent in 2001), although the state ranks 45th in the nation in terms of number of nursing home beds per resident aged 65 and over. Reductions to IHSS at a time when demographic and programmatic changes are increasing demand for long-term care services may lead to increases in utilization of out-of-home care at substantially higher costs to the state.

Governor's Budget: The Governor's budget proposes to reduce IHSS expenditures by 35 percent from their current law level for total reductions of $991.7 million ($581.2 million General Fund).

Subcommittee request and questions: The Subcommittee has requested that the Department of Social Services answer the following questions:

1. Briefly describe the IHSS program, its purpose, and its target population.
2. What is the role of the IHSS program in the state's long term case system and the system of services that assists low-income people with disabilities in living independently?
3. How have the IHSS caseload and program costs changed over the last decade?
4. How has the IHSS caseload composition and service hour utilization changed over time?
5. Where has the growth in IHSS caseload, hours of service, and program costs occurred?

Issue A - Eliminate the IHSS Residual Program

Background: The Residual program serves 75,000 low-income aged, blind or disabled consumers. The Residual program funds services that are not eligible for federal financial reimbursement through Medicaid. Program consumers meet the same income, resources and disability eligibility criteria as IHSS PCSP beneficiaries. Whether consumers receive services from the Residual program, the PCSP program, or both, depends on whether the services they require and their arrangement for receiving care qualifies for federal financial reimbursement.

The IHSS Residual program funds the following IHSS services: (1) Cases where the recipient receives payment in advance of service delivery; (2) Services delivered to consumers who only require assistance with domestic chores; (3) Services delivered to minor children whose IHSS provider is a parent and services delivered to consumers whose IHSS provider is a spouse; (4) Protective supervision services provided to clients with cognitive impairments who need around the clock care; (5) Restaurant meal allowances to consumers who receive those services.

In November 2003, the utilization of Residual Services was the following:

Categories of Services	Monthly Cases	Percentage	Monthly Expenditures	Percentage
Total	**63,556**		**$42,261,294**	
Advanced Pay	838	1.32%	$1,577,082	3.73%
Domestic Services Only	27,598	43.42%	$7,653,134	18.11%
Relative Caregiver	20,345	32.01 %	$13,210,872	31.26%
Protective Supervision	13,210	20.78%	$17,756,220	42.02%
Misc./Unknown	3,921	6.17%	$2,175,122	5.15%

** Expenditure and caseload data included in this chart is monthly data. As such, the data does not "tie" to the caseload and expenditure numbers referred to in the narrative and in the Governor's Budget.*
***The chart contains some duplication both for cases and expenditures as a case may be considered both domestic service only and relative caregiver. The total number of cases and expenditures is based on unduplicated cases. The percentages are derived from unduplicated cases and expenditures.*

Governor's Budget: The Governor proposes to eliminate the IHSS Residual Program effective April 1, 2004, for $116.1 million ($88.8 million General Fund) in savings in 2003-04 and $485.4 million ($365.8 million General Fund) in savings in 2004-05.

Impact of Proposal: The impact of the proposed elimination of the IHSS Residual program will vary across program categories and consumer types as consumers have different needs and varying levels of alternative resources. Persons that only receive domestic services may have a lower risk of immediate placement in out-of-home care than persons who receive advance pay or protective supervision services. While neither the Administration nor Subcommittee staff know with a degree of certainty how consumers will be affected by the proposal, a review of program data establishes who receives services and provides information on the impact of reductions.

Thirty-three percent of consumers will remain eligible for IHSS services. Specifically, persons whose service provider is a parent or a spouse and persons who receive payment prior to service delivery will remain eligible. To continue receiving services, these consumers will need to alter their existing provider arrangement (i.e. hire a new provider who is not a parent). These consumers account for thirty-five percent of IHSS Residual program expenditures.

Consumers that only receive domestic services will become ineligible for services. They comprise 43 percent of the Residual caseload and account for 18 percent of expenditures. These consumers are relatively more independent than other IHSS Residual clients and are considered less likely to require out-of-home care as a result of losing IHSS. According to DSS program data, 63 percent of consumers that only receive domestic services will require out-of-home care as a result of losing IHSS services.

Consumers that receive protective supervision will lose over 64 percent of the hours of service they currently receive. These consumers constitute 21 percent of the caseload and account for 42 percent of expenditures. According to DSS program data, sixty percent of these consumers need at least some human assistance to perform activities of daily living. Only 3 percent of these consumers are considered independent. According to social worker assessments, 87 percent of consumers receiving protective supervision will require out-of-home care as a result of losing IHSS services.

Budget Assumptions: The Budget assumes that 24 percent of consumers will change their provider arrangement to transition to PCSP. The estimate is based on the number of consumers who receive services from a spouse or ineligible parent. The Budget does not establish a process for these consumers to transition to PCSP. DSS indicates that a notice of action regarding termination of the program may inform consumers of their right to an assessment and that if they receive care from a responsible relative they can receive PCSP services by changing providers.

Potential Cost increases not included in the Budget: The Governor's Budget appears to over estimate the level of savings resulting from the proposed elimination of the Residual program. The Budget underestimates the number of consumers that may transition to PCSP. In addition, the Budget does not account for an increase in Regional Center costs though a portion of Residual expenditures is associated with Regional Center consumers. Lastly, the Budget assumes

that the elimination will not increase demand for out-of-home care although IHSS is required by statute to serve consumers who can not safely remain at home without program services.

Consumers receiving IHSS services from a responsible relative are not the only consumers that can transition to PCSP. Advance pay consumers are eligible for PCSP. Further, consumers receiving protective supervision and consumers receiving domestic services only may be eligible for additional PCSP hours or become eligible for PCSP if re-assessed. The Budget does not fund increased demand for PCSP services among these consumers.

The Governor's Budget does not assume an increase in Regional Center costs resulting from the proposed reductions in IHSS services. Persons with developmental disabilities will remain entitled to like services under the Lanterman Act. In 1997, persons with developmental disabilities represented 12 percent of the IHSS caseload, 69 percent of cases with a parent provider and accounted for 41 percent of protective supervision expenditures. Since December, Subcommittee staff has repeatedly requested from the Administration, data regarding the number of IHSS consumers that are Regional Center clients and the amount and types of services they receive. **The Subcommittee still has not received the requested information, which is necessary to assess the level of savings to be realized from the proposed elimination of the Residual program.**

The budget does not assume an increase in costs for institutional care resulting from the proposed reductions in IHSS services. According to program data, 63 percent of Residual consumers will require out of home community care and 12.6 percent will require out of home medical care without IHSS. A review of consumers terminated from IHSS found that the most common reason consumers left the program was due to death (29%). Fifteen percent of IHSS recipients transitioned to institutions, 10 percent left at their own request, and 22 percent had a change in eligibility. More recent data shows an increase in the number of persons leaving IHSS to out-of-home care, while the number of consumers who leave due to death remains stable. Approximately 20 percent of cases exit IHSS every year.

Alternatives to the Governor's proposal: California may wish to seek increased federal financial participation in IHSS program costs as an alternative to the Governor's proposed elimination of the Residual program. The state could seek such funding through a Medicaid waiver, including a relatively broad 1115 waiver. At least three states, New Jersey, Florida and Arkansas have been approved by the federal government to provide payment to legally responsible relatives using federal Medicaid dollars. States also receive federal Medicaid funds for services similar to protective supervision. For example, New Mexico appears to use federal Medicaid dollars to fund services similar to protective supervision. Additionally, a federal regulatory change that broadened the definition of personal care services may provide federal Medicaid funding for IHSS cases that only require domestic or ancillary services through an amendment to the state Medicaid plan.

When considering the aforementioned options for increased federal financial participation in IHSS program costs, the state will likely benefit from analyzing the implications to the program of operating under Medicaid requirements. Federal Medicaid law generally requires that service

utilization controls consider medical necessity and individual needs, and do not result in arbitrary denial of services. Medicaid law also requires that services made available to any categorically needy individuals not be less in amount, duration, or scope than those services made available to medically needy individuals, and that services made available to any individuals in the categorically needy or medically needy group must be equal in amount, duration, and scope for all individuals within the group. EPSDT requires states to provide eligible children any medically necessary services to correct or ameliorate physical and mental illnesses and conditions, if the services are within the scope of mandatory or optional services under federal law, whether or not such services are covered for adults in the state's Medicaid program. Administering the Residual program in accordance with Medicaid may require program changes.

Subcommittee questions and requests: The Subcommittee has requested that the Administration respond to the following questions:

1. Please briefly describe the Governor's proposal, budget assumptions and the population that receives services from the IHSS Residual program.
2. How will the proposed elimination of the IHSS Residual program impact California's compliance with the *Olmstead* decision?
3. What may happen to consumers receiving services from the Residual program if they lose program services? What types of services or resources will remain available to them? How will consumers receiving advance pay or consumers who require protective supervision manage without program services?
4. What percentage of individuals on the Residual program will require out-of-home care in the absence of IHSS within 6 months and within 12 months?
5. Reductions to IHSS may result in cost increases to other programs. For example, persons with developmental disabilities who lose IHSS services will remain entitled to like services under the Lanterman Act. To what extent may the proposed elimination result in offsetting cost increases, including increased demand for Regional Center service or for out-of-home care?
6. Has the Administration fully explored potential increases in federal financial participation to fund IHSS Residual program costs? What are the obstacles to obtaining increased federal funding for the services currently funded by the Residual program?

Budget issue: Does the Subcommittee wish to approve the proposed program elimination?

Issue B - Eliminate State Participation in IHSS Provider Wages above Minimum Wage

Background: In 1999, California enacted legislation to provide state participation in provider wages up to 50 cents per hour above minimum wage for increases negotiated prior to or during the 1999-2000 fiscal year. Through higher wages for IHSS providers, the state sought to increase the ability of consumers to hire and retain qualified providers; to improve the quality of program services; to reduce service provider turnover; and to more adequately compensate providers for the services they provide. California expanded its commitment to higher wages for IHSS providers in 2000, when it enacted legislation to provide state participation in IHSS provider

wages and benefits up to a maximum of $12.10 per hour. Currently, the state participates in wage costs up to $9.50 per hour, and benefit costs up to $0.60 per hour.

The average wage for IHSS service providers is $8.10 per hour. Twenty-three counties, that together account for more than 80 percent of the state's IHSS caseload, provide health benefits to at least some IHSS providers.

Governor's Budget: The Governor proposes to reduce state participation in IHSS provider wages and benefits from $10.10 to the state minimum wage ($6.75) for savings of $301.6 million ($98 million General Fund) in 2004-05. The budget assumes a phased-in implementation reducing state participation in wages as existing collective bargaining agreements and contracts with private contractors expire. The effect of the Governor's proposal is that upon expiration of current collective bargaining contracts, counties will have to reduce IHSS provider wages or replace current state funding for provider wages with county funds.

According to DSS, the impact of the proposed reductions on the ability of consumers to find and retain qualified providers will depend on the county and on the provider/consumer relationship. DSS notes that the majority of counties (36) pay wages that are at the minimum wage or no greater than minimum wage plus 5.31 percent ($7.11 per hour). Eighty-eight percent of IHSS consumers live in counties that pay higher wages. DSS states that wage reductions may not have a significant impact on the ability of consumers to hire a worker in counties that pay lower wages. However, the vast majority of consumers live in counties that pay higher provider wages.

Opponents of the Governor's proposal argue that reducing state participation in wages to the minimum wage will increase the chances that IHSS workers live in poverty and increase the number of uninsured Californians. IHSS providers on average work less than 23 hours per week and earn $436 per month. Seventy-seven percent of IHSS providers rely on their IHSS wages as their only source of income. Twenty percent of providers rely on the Medi-Cal program for their health insurance. Wage reductions will likely decrease the resources available to IHSS providers and may increase their reliance on public assistance programs.

Opponents of the Governor's proposal also argue that reducing state participation in wages will take millions of dollars out of local economies and will negatively affect quality of care. Opponents state that wage reductions will decrease the number of available providers, increase provider turnover and worsen the quality of care.

Reductions in provider wages may reduce state tax revenues and increase program costs. According to DSS, there are approximately 265,000 IHSS providers in California. Seven percent of providers are CalWORKs recipients. Income decreases for providers enrolled in CalWORKs will likely increase grant costs in the budget year.

Subcommittee request and questions: The Subcommittee has requested that the Administration answer the following questions:

1. Please describe the Governor's budget proposal.
2. How will the Governor's proposal effect the ability of consumers to hire a provider, provide turnover and quality of care?
3. What is the estimated effect of the Governor's proposal on CalWORKs grant costs?

Budget issue: Does the Subcommittee wish to approve the Governor's proposal to reduce state participation in IHSS provider wages to the minimum wage?

Issue C - IHSS Employer of Record and Advisory Committees

Background: In 1992, California enacted legislation to define the role of Public Authorities established by County Boards of Supervisors to provide for the delivery of IHSS. Public Authorities are the employer of record of IHSS providers for purposes of collective bargaining. IHSS consumers retain the right to hire, fire and supervise their service provider. In addition to being the employer of record, Public Authorities are required to establish and operate a provider registry, to investigate the qualifications and background of potential providers, and to provide training for providers. According to DSS, three counties operated public authorities in 1998.

In 1999, California enacted legislation that required counties to establish an employer of record for IHSS providers by January 2003. Most counties established a public authority to meet the employer of record requirement. Five small counties chose to become the employer of record.

Chapter 90, Statues of 1999, (Assembly Bill 1682) also required counties to establish local IHSS Advisory Committees to be comprised of no more than 11 members, at least 50 percent of whom must be current or past consumers of IHSS services. The Committees were required to submit recommendations to the county board of supervisors on the preferred mode or modes of service to be utilized in the county for In-Home Supportive Services. Committees provide ongoing advice and recommendations regarding IHSS to the county board of supervisors and to entities responsible for the administration of the program or delivery of IHSS services.

Governor's Budget: The budget proposes to: (1) repeal the existing IHSS Employer of Record requirement; (2) eliminate state funding for Public Authorities; and (3) make the establishment of county IHSS Advisory Committees optional for savings of $7.6 million ($2.2 million General Fund) in the budget year.

The Governor's proposal may reduce the availability of training for IHSS providers and employee registries as counties would not be required to assume existing public authority responsibilities. Opponents of the Governor's proposal argue that the Governor's proposal will lower IHSS program and administration standards and reduce access to quality assurance efforts including provider screens, training and provider registries. Opponents also argue that the Governor's proposal will reopen litigation regarding the legal status of IHSS workers and the liability of the state as the potential employer.

According to DSS, consumers likely will continue to receive assistance in obtaining a provider as regulations require that counties make reasonable efforts to assist recipients who are unable to obtain a provider independently. Counties are also required to notify recipients of the availability of provider fingerprinting. DSS states that prior to the establishment of Public Authorities, counties had some provider referral services available and that some counties receive Supported Individual Provider funding which permits claims for registry maintenance costs. On the issue of training, DSS states that it is unclear how much training is currently available as the mandate is that there be access to training, not that a certain level of training be provided.

Subcommittee request and questions: The Subcommittee has requested that the Administration briefly describe the budget proposal, its impact on the availability of training and provider registries, and its potential effect on the quality of program services.

Budget issue: Does the Subcommittee wish to approve the Governor's proposals to repeal the existing IHSS Employer of Record requirement, eliminate state funding for Public Authorities, and make the establishment of county IHSS Advisory Committees optional?

Issue D - Selective Elimination of Domestic Services

Background: IHSS supports the provision of domestic services to eligible low-income aged, blind or disabled consumers that need the services to remain safely in their own homes. Domestic services include sweeping, kitchen and bathroom cleaning, changing bed linens, meal preparation and clean-up, laundry services, and shopping for food. Consumers who reside independently can receive these services based on their level of need, subject to a state cap (6 hours per month for domestic services, 3 hours per week for laundry and shopping). Services for consumers who reside in shared living arrangements are pro-rated or reduced to reflect the consumer's use of common areas and shared meals. For example, if an IHSS consumer resides with two other adults, IHSS will fund the time to perform domestic services in one-third of the common areas or one-third of the time required to prepare shared meals. Approximately 39 percent of IHSS consumers reside in shared living situations.

Governor's Budget: The Governor proposes to eliminate coverage for domestic services when consumers reside with other family members to realize savings of $80.9 million ($26.3 million General Fund) in 2004-05.

The Budget assumes savings commensurate with a reduction in the authorized IHSS service hours of 90,000 persons. The estimated impact is based on the assumption that 65% of the 139,000 IHSS consumers in shared living arrangements reside with relatives. The 65% estimate is based on the experiences of the Adult Program Branch's Evaluation and Integrity Staff who conduct home visits and on other anecdotal information.

Services subject to the Governor's proposal include sweeping, kitchen and bathroom cleaning, changing bed linens, meal preparation and clean-up, laundry services, and shopping for food. According to DSS, the definition of family member for purposes of this proposal is under development but current thinking is to define family member as "an adult who resides with the recipient and is related by blood, marriage, including common-law, or adoption."

The budget proposes the following exemptions: (1) when the recipient resides only with minor children; (2) when there is sufficient indication that the need cannot or should not be met in common; or (3) when there is substantiation that the other family members are not able to provide the services. Exemptions will be granted as part of the assessment process, and are not expected to significantly increase county workload. Exemptions based on the family member's inability to provide the services will require medical substantiation and may increase county costs. The budget does not estimate the percentage of cases that will be eligible for exemptions but assumes that the numbers will be small.

Staff Comment: The Governor's proposal may conflict with Medicaid comparability requirements as it would result in disparate treatment for similarly situated beneficiaries. Specifically, federal law requires that services made available to any categorically needy individuals not be less in amount duration or scope than those services made available to medically needy individuals. In addition, services made available to any individual in the categorically needy or medically needy group must be equal in amount, duration and scope for all individuals within the group.

Subcommittee request and questions: The Subcommittee has requested that the Administration answer the following questions:

1. Briefly describe the Governor's proposal, budget assumptions and the population affected by the proposal.
2. What is the basis for the budget assumption that 65 percent of consumers in shared living situations reside with relatives?
3. How will the budget proposal impact consumers?
4. What percentage of hours of service will consumers in shared living arrangements lose?
5. How do you reconcile the proposal with Medicaid comparability rules, which require that services made available to any individual in the categorically needy or medically needy group be equal in amount, duration and scope for all individuals within the group?

Budget issue: Does the Subcommittee wish to approve the Governor's proposal to eliminate coverage for domestic services when a consumer lives with a relative?

Issue E - Quality Assurance

Overview of IHSS Assessment, Quality Assurance and Utilization Control Requirements:

Assessment: State law requires that IHSS be administered in a uniform manner in every county and provides that utilization controls can be established for the PCSP program. Since 1988, the state has used the Uniformity System and the uniform assessment form to determine a consumer's level of need and to authorize service hours. California uses the Uniformity system and the uniform assessment form to authorize service hours under PCSP and Residual.

Using the assessment, state regulations and county policies, county social workers determine the degree of assistance required by a recipient in performing Activities of Daily Living and Instrumental Activities of Daily Living, record the amount of time required to assist the recipient in completing tasks, and assign a Functional Index ranking. (The Functional Index ranking is the consumer's relative need for IHSS. 1 means consumer is independent. 5 means consumer cannot perform function without human assistance.) During the assessment process, social workers identify other resources available to the consumer. Based on the level of needs assessed, the time required to meet the needs, and the level of available resources, social workers authorize IHSS service hours.

California establishes regulatory guidelines for some IHSS services (housework, laundry, and shopping). According to DSS, federal and state regulations do not allow guidelines for meal preparation and cleanup, personal care services and paramedical services. The number of hours authorized for personal care services, paramedical services and meal services is solely based on the social worker assessment, subject to the state's caps of 283 hours for PCSP consumers and Residual consumers who are severely impaired, and 195 for Residual consumers who are not-severely impaired. California does not have a uniform definition of what constitutes an alternative resource or specify how having such resources affects the level of service hours authorized (i.e. How does receipt of meals on wheels or adult day health care services affect the level of IHSS service hours authorized?).

Counties are required to conduct individual assessments at least once a year. Counties are also required to conduct assessments when requested to do so by the beneficiary; when a beneficiary moves to a different county; or when the county has information that indicates that the client's condition or living arrangement has changed. Counties can conduct more frequent assessments but are not funded to do so.

IHSS consumers have a right to challenge eligibility determinations, the social worker assessment and the level of service hours authorized. Information about the number of state hearings filed and the outcome of such hearings is limited. When a county assessment results in a reduction of service hours from the previously approved level, the county is required to maintain the higher level of hours pending the Administrative Law Judge (ALJ) decision. If the beneficiary is requesting an increase to the existing level of hours authorized or is a new consumer, the assessed and approved hours remain pending the ALJ decision.

Quality Assurance: The Department of Social Services has very limited resources to conduct quality assurance efforts (3 staff). Counties also have limited ability to conduct in-home monitoring of quality of care and quality assurance. Generally, to conduct quality assurance counties must redirect staff from required activities to quality assurance efforts. Counties tend to learn of changes in a beneficiary's status when the beneficiary, providers or relatives report such changes or when the county conducts annual assessments.

IHSS and Medicaid law: Services under IHSS PCSP are federally reimbursable under the Medicaid program and as such, are subject to federal Medicaid requirements. A beneficiary eligible for PCSP services can receive personal care services, up to 283 hours per month. There are currently no limitations on the number of personal care services that can be provided within a specified time frame, as long as the monthly hours do not exceed 283. Eligibility for services and the level of hours authorized is based on the Uniformity System and the IHSS assessment.

According to the Department of Health Services (DHS), state law authorizes DHS to adopt utilization controls for PCSP. Utilization controls for personal care services are limited to:

- Prior authorization, which is approval by a department consultant, of a specified service in advance of rendering that service based upon a determination of medical necessity;
- Postservice prepayment audit, which is a review for medical necessity and program coverage after service was rendered but before payment is made;
- Postservice postpayment audit, which is review for medical necessity and program coverage after service was rendered and the claim paid;
- Limitation on number of services, which means certain services may be restricted as to number within specified time frame; and
- Review of services pursuant to Professional Standards Review Organization agreements entered in accordance with Section 14104.

As a Medi-Cal service, IHSS PCSP services are subject to federal Medicaid requirements. Relevant Medicaid requirements include: **(1)Comparability** - requires that services made available to any categorically needy individuals not be less in amount duration or scope than those services made available to medically needy individuals and that services made available to any individuals in the categorically needy or medically needy group must be equal in amount, duration and scope for all individuals within the group; and **(2) EPSDT** which requires states to provide eligible children any medically necessary services to correct or ameliorate physical and mental illnesses and conditions, if the services are within the scope of mandatory or optional services under federal law, whether or not such services are covered for adults in the state's Medicaid program. Generally, federal and state law permits adoption of utilization controls as long as such controls consider medical necessity, consider individual needs, and do not result in arbitrary denials of services. Utilization controls must be consistent with federal and state law, and case law, including specific restrictions to or prohibition of the adoption of controls.

Governor's Budget: The Governor's Budget states that according to DSS case reviews, up to 25 percent of all paid services under the IHSS program may be unnecessary or not actually provided. The Budget establishes the Administration's intent to develop a May Revision proposal to improve the quality of assessments and reduce over-authorization of hours.

The Governor's Budget estimate of 25 percent is based on state reviews of a limited number of IHSS cases conducted over a seven-year period (May of 1996 to April 2003). The state reviewed an average of 37 cases in 22 counties. It is unclear how the cases were selected and the methodology employed in conducting the reviews.

The counties examined by the state account for only 24.5% of total IHSS expenditures. The substantial differences (5% or more) in hours authorized were concentrated in a few counties. In counties that account for 11 percent of expenditures the difference between the state and county authorized hours was 1.31 percent. The Governor's Budget assumes that data gathered over 7 years in counties that serve 13 percent of the caseload is representative of the entire state.

Staff Comments: Although the Administration's estimate of the level of unnecessary expenditures in IHSS may not be representative of what is happening statewide, review of county specific data and anecdotal evidence suggest there are differences between counties and among workers in the number of service hours authorized across case types. California may benefit from development and adoption of quality assurance mechanisms, uniform program guidelines and standardization of social worker training.

Although the IHSS caseload and program expenditures have more than doubled since the early 1990s there have been few systematic efforts to promote effective and efficient program operations. For example, California has not updated regulations since it made personal care services an entitlement for eligible Medi-Cal beneficiaries through the creation of PCSP in 1993. The absence of PCSP regulations leads to different interpretations of program requirements from one county to the next and contributes to decisions by state hearing officers to overturn county decisions in appeals. Additionally, the absence of regulations and different standards between the PCSP and Residual programs may negatively impact fraud prevention and intervention efforts.

According to counties, outdated IHSS workload standards and budgeting methodologies do not allow the level of service necessary to conduct needed quality assurance activities. The Budget grants 11 hours of county time annually per case, intended to encompass all assessment activities, time-sheet processing, annual reassessment, and additional reassessments conducted upon request of the recipient. The Budget does not provide reimbursement for county activities, including required assessments and eligibility services, when consumers are found ineligible for program services. Counties report that even in straightforward cases, assessments can take several hours, including time to interview the client, relatives, and medical professionals. Additionally, counties report that the lack of guidance and adequate funding limits the ability of counties to systematically perform certain activities that may reduce costs, such as periodic reassessments of clients whose condition may improve and require fewer hours of services.

The lack of PCSP regulations and the absence of uniform guidelines contribute to variances in the number of authorized services hours across cases and counties. Standardized training, assessments, fraud prevention and intervention, and quality control programs will likely generate budgetary savings and improve the match of program services to identified client needs. Clearly defining fraud and establishing regulations governing fraud prevention and prosecution will likely reduce its incidence. In addition, the state may benefit from considering IHSS utilization in the context of other available resources and improving coordination of long-term care services.

The Governor's Budget establishes the Administration's intent to develop a proposal to improve the quality of assessments and reduce over-authorization of hours, but provides very limited details of what such a proposal should include. Counties indicate that the following are essential components of an effective IHSS quality assurance program: (1) standardized, updated tools for IHSS staff, including updated regulations and guidelines for assessing clients and calculating service hours; (2) a statewide, standard quality control system; (3) uniform training, both upfront and ongoing; (4) enhanced IHSS fraud investigation; and (5) staff capacity to conduct initial assessments and special, periodic reassessments.

A comprehensive quality assurance program will likely generate budgetary savings and improve program quality. Such a program may also result in a better match of program services to identified client needs. However, depending on how it is crafted, a quality assurance program may alter the IHSS program's design, limit flexibility and impact client access to program services. When developing a comprehensive quality assurance program the state may benefit from stakeholder involvement, including input from consumers, providers and counties.

Development and implementation of a comprehensive quality assurance program may be complicated and require increased state and county administrative resources. For example, efforts to standardize program services may require statutory and regulatory changes. Changes to IHSS PCSP including, adoption of caps on services or changes to the scope of covered services would require federal authority, a change in state law and State Plan amendment. Specifically, changes, additions, or modifications to PCSP must be reflected in the Medicaid State Plan. A state plan amendment would require federal approval. Certain policy changes (i.e., restructuring models of care delivery, changing benefits, etc.) to PCSP would require a federal waiver.

Subcommittee request and questions: The Subcommittee has requested that the Department of Social Services answer the following questions:

1. Briefly describe existing IHSS quality assurance and utilization control requirements.
2. What factors impede county staff efforts to monitor quality of care? How does the IHSS Administration funding structure affect quality assurance efforts?
3. How do the interactions between Medicaid law and IHSS impact California's ability to adopt utilization controls and implement quality assurance strategies?
4. What is the basis for the Administration's assertion that up to 25 percent of all paid services under the IHSS program may be unnecessary or not actually provided?
5. What is the Administration's timeline and process to develop a quality assurance proposal? What types of strategies to improve quality assurance is the Administration considering? How might the proposed changes impact consumer access to services?

Budget issue: Does the Subcommittee wish to develop an IHSS quality assurance program that better matches program services to identified client needs and results in budgetary savings?

Issue G - Quality Provider Fee

Background: Under the authority of the Social Security Act, Title 19, Section 1903(w)(7)(A), a state may impose a "quality assessment fee" on certain health care providers. Fee revenues can be used to obtain federal matching funds. The state can use the additional matching funds to support increases in provider reimbursement. The funds can also be used to offset state costs.

Federal law requires (42 CFR 433.68) the fee (maximum of 6 percent) to be uniformly imposed on *all* provider revenues, a class of services, or a bed fee or license fee. The collected fees are then used to draw down additional federal funds. Several states currently use this mechanism for nursing homes and hospitals. The Governor is proposing to use this option for Medi-Cal Managed Care Plans in order to obtain a federal match, provide a rate increase for Medi-Cal Managed Care providers, and save about $75 million in state General Fund support.

Legislative Analyst's Office Comments: The LAO writes that "One potential source of funds to support [an IHSS] quality assurance program would be a fee on providers. Providers would be "held harmless" because the proposed fee would be offset by a corresponding wage increase. All providers would pay the fee and receive the wage increase. The wage increase paid to PCSP providers would draw down federal funds through Medicaid. These federal funds would free up some of the fee revenues that otherwise would be needed to fund the wage increase for PCSP providers. The freed-up fee revenues could be used to fund a quality assurance program".

The LAO generally points out that there may be winners and losers from implementation of a quality assessment fee. Because federal law requires that the fee apply to all providers within a defined class of providers, providers that are required to pay the fee but do not provide services to Medi-Cal beneficiaries would not benefit from a reimbursement increase. When a fee is imposed across a class of medical service providers, any non-Medicaid providers indirectly share part of the burden of caring for Medicaid beneficiaries through their fee payments. While some would contend that it is only fair that the burden of providing health care for the poor be shared in this way, other providers are likely to object to such an arrangement.

Staff Comment: California may benefit financially from requiring a "quality assessment fee" from IHSS providers and using fee revenue to obtain increased federal funds. However, it may not be federally allowable or programmatically feasible to implement the Medicaid "quality assessment fee" in the IHSS program.

Federal law permits the assessment of quality assurance fees on providers of "home health care services". The Department of Social Services is working with the Department of Health Services to determine whether IHSS providers can be considered "home health care services" providers under federal law. The Administration's initial review suggests that under state and federal regulatory definitions, providers of "home health care services" means "home health agencies", and does not include IHSS providers.

Home health agencies are entities licensed by the state to provide skilled nursing services, therapy services, including physical therapy and occupational therapy, medical social services, and home health aide services. Home health aide services are defined as personal care services provided by a person certified by the state as a home health aide under a plan of treatment prescribed by the patient's physician. Some home health agencies participate in the Medi-Cal program, however the vast majority of their business is with the Medicare program, not with Medi-Cal. According to data from the Office of Statewide Health Planning and Development, Medi-Cal accounted for only 6 percent of the reimbursements received by home health agencies in 2001.

In addition to the fact that IHSS providers may not qualify under the definition of providers of "home health care services", there are technical issues that complicate implementation of a quality assessment fee on IHSS providers. Under federal law, quality assessment fees must be uniformly imposed on all provider revenues, a class of services, or a license fee. There are over 250,000 IHSS providers in California that are compensated for varying levels of work in at least ten different reimbursement levels. Twenty-three percent of providers have earnings beyond their IHSS wages. IHSS providers are not licensed and are not the exclusive home health care service providers in the state. Additionally, CMIPS, the IHSS payrolling system, does not have a mechanism to make payroll deductions.

Subcommittee request and questions: The Subcommittee has requested that the Legislative Analyst's Office describe the Medicaid quality assessment fee option and how implementation of this option might benefit the IHSS program. The Subcommittee has also requested that the Administration comment on the feasibility of implementing this fee in the IHSS program.

Budget issue: Does the Subcommittee wish to adopt a "quality assessment fee" in the IHSS program?

III - Supplemental Security Income/State Supplementary Program (SSI/SSP)

General Background: The SSI/SSP program provides cash grants to persons who are elderly, blind and/or too disabled to work and who meet the program's federal income and resource requirements. Individuals who receive SSI/SSP are categorically eligible for the Aged, Blind or Disabled Medi-Cal Program with no share-of-costs They may also be eligible for the In-Home Supportive Services Program and for other programs designed to keep individuals living in the community like the Multipurpose Senior Services Program.

The SSI/SSP program is administered by the federal Social Security Administration. The Social Security Administration determines eligibility, computes grants, and disburses monthly payments to recipients. The state establishes the level of State Supplementary Payment support for individuals and contributes the funds for this portion of the program.

SSI/SSP grant levels vary based on a recipient's living arrangement, marital status, minor status and whether she or he is aged, blind or disabled. Currently there are 19 different SSI/SSP payment standards. These standards are generally adjusted each calendar year. The current maximum grant for an aged or disabled individual living independently is $790 per month. It is $1,399 for couples living independently.

Summary of Enrollment. Approximately 1.2 million Californians receive SSI/SSP. Over two-thirds of the recipients are disabled, 30 percent are elderly, and two percent are blind. The budget estimates that program enrollment will grow by 2.2 percent in the 2003-2004 fiscal year, and by 2.1 percent in the 2004-2005 fiscal year. The total caseload for 2004-2005 is estimated to be 1,178,000. Due to changing demographics and a projected increase in California's aging population, the SSI/SSP program caseload is likely to continue to grow in future years.

Summary of Funding. The budget proposes basic SSI/SSP program costs for the 2004-2005 fiscal year to be $7.7 billion ($2.9 General Fund).

Issue A - Elimination of Pass-Through of Federal SSI Cost-of-Living Adjustment

Background: Federal law provides a cost-of-living adjustment to the SSI portion of grants that is based on the Consumer Price Index. Since January 2004, state law provides automatic pass-through of the federal COLA to SSI recipients. In January 2005, the federal SSI adjustment will increase the maximum grant for an individual by $10 to $800 per month.

Governor's Budget: The Budget proposes to withhold the federal COLA for $62.5 million in General Fund savings. Essentially, the budget proposes to reduce the SSP component of the grant by the same amount as the federally funded January 2005 SSI COLA, thereby reducing state SSP expenditures in the budget year.

Subcommittee request and questions: The Subcommittee has requested that the Administration describe the Governor's proposal, its effect on the level of the SSP payment and its impact on SSI/SSP beneficiaries.

Budget issue: Does the Subcommittee wish to adopt the Governor's proposal to suspend pass-through of the federal January 2005 SSI COLA?

Issue B - Suspension of State SSI/SSP Cost-of-Living Adjustment

Background: Current law provides an annual state COLA for SSI/SSP grants, which is based on the California Necessities Index. The scheduled COLAs will increase the maximum SSI/SSP grant for an individual from $790 to $812, and from $1,399 to $1,438 for couples.

Governor's Budget: The budget suspends the 2004-2005 state cost-of-living adjustment for the SSI/SSP program to realize savings of $84.6 million. Suspension of the state COLA will maintain grants at a level that does not keep pace with cost-of-living increases such as rising housing costs.

California's SSI/SSP beneficiaries are ineligible for Food Stamps benefits and depend on their grants to pay for rent, food, clothing and other necessities. Beneficiaries expend most of their grant on rent and utilities. According to the U.S Department of Housing and Urban Development, fair market rents for a studio apartment in California average $537 per month and range from $341 in Alpine to $1,294 in Santa Clara. Since 1990, rent prices have increased by 41 percent and the SSI/SSP purchasing power has declined by 18 percent.

Subcommittee request and questions: The Subcommittee has requested that the Administration describe the Governor's proposal and its impact on SSI/SSP beneficiaries.

Budget issue: Does the Subcommittee wish to adopt the Governor's proposal to suspend the state SSI COLA in the budget year?

In-Home Supportive Services Program history

1959 California began funding attendant services for persons with disabilities on a limited basis following the discovery of the polio vaccine and a reduction in privately funded services for persons who became disabled from the disease.

1963 California provided eligible disabled persons up to $300 per month for attendant services.

1974 California established the Homemaker Chore program (now IHSS) which was funded by the General Fund, federal Title XX funds, and a limited county share-of-cost (3%). IHSS operated as a capped entitlement in the 1992-93 and 1993-94 fiscal years.

1988 California adopted statutory monthly caps on service hours (283 for severely impaired and 195 for non-severely impaired) to replace fixed monthly dollar caps on funding for services.

1991 State-Local Realignment increased the county-share of funding for IHSS to 35 percent. Realignment authorized DSS to implement a uniform IHSS assessment tool.

1992 California enacted legislation to define the role of Public Authorities (PAs) as the employer of record of IHSS providers for purposes of collective bargaining and made PAs responsible for training providers, operating employee registries, etc.

1992 California pursued a Medicaid State Plan amendment to provide personal care services as a Medi-Cal service. The amendment allowed California to draw down Title XIX funding (Medicaid) for IHSS and established IHSS/PCSP as a service Medi-Cal beneficiaries are entitled to receive if it is determined that they need the service to safely remain at home.

1993 California established the Personal Care Services Program (PCSP) to provide IHSS services to eligible Medi-Cal beneficiaries. PCSP costs are funded by a combination of federal (50%), state (32.5%) and county (17.5%) dollars. California maintained the IHSS Residual program to fund services ineligible for federal funding and services received by consumers whose arrangement for receiving care does not qualify for federal funding. Specifically, the IHSS Residual program funds services of consumers whose provider is a parent or a spouse, protective supervision, services of persons with severe disabilities who receive payment prior to service delivery, services of consumers who only require assistance with domestic chores and restaurant meal allowances.

1994 California eliminated the requirements that a physician "prescribe" personal care services and that a nurse review IHSS assessments as a condition of receiving services.

1997 Legislation provided state participation in funding Public Authority Administration costs.

1999 California implemented the IHSS share-of-cost buy-out whereby the state pays the beneficiary's Medi-Cal share-of-cost to serve the consumer through PCSP. The share-of-cost funded by the state is the difference between the Medi-Cal Medically Needy maintenance need income level ($600) and the maximum SSI/SSP grant ($790).

1999 Legislation provided state participation in provider wages up to 50 cents per hour above minimum wage for increases negotiated prior to or during the 1999-2000 fiscal year. Funding for the non-federal share of wage increases was state (80%) and county (20%).

1999 Legislation required counties to establish an employer of record for IHSS providers by January 2003 and to establish local IHSS Advisory Committees.

2000 California enacted legislation to provide state participation in IHSS provider wages and benefits up to a maximum of $12.10 per hour. Currently, the state participates in wage costs up to $9.50 per hour, and benefit costs up to $0.60 per hour. Funding for the non-federal share of wage and benefit costs is state (65%) and county (35%).

2000 California extended Medi-Cal eligibility to Aged, Blind or Disabled persons with incomes below 133 percent of the federal poverty level.